



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:

ST MARY'S BEHAVIORAL PAIN MANAGEMENT
3033 FANNIN STREET
HOUSTON, TX 77004

MFDR Tracking #: M4-11-0169-01

DWC

Injury

Respondent Name and Box #:

TEXAS MUTUAL INSURANCE CO
Box #: 54

Date

Employer

Insurance Company

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting your assistance in processing the medical bills related to the above-mentioned patient for DOS 04/06/2010. Payments were denied for the following reason:

- Claim/service lacks information needed for adjudication
- This procedure code is inconsistent with the modifier used or a required modifier is missing

CPT code, 99213- Established office visit, does not require a modifier. Please find attached the sufficient documentation that is being submitted in this request. All previous DOS for the same charges have been reviewed and paid in full. I am also including a copy of a paid EOB for DOS 2/10/2010. Please review the submitted documents and expedite payment to St. Mary's Behavioral Pain Management."

Amount in Dispute: \$100.84

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. 1. Denise Weinberg, MSW LMFT, provided a psychological evaluation of the claimant as a candidate for a chronic pain management program. The requestor billed this to Texas Mutual under E&M code 99215. Texas Mutual denied reimbursement on the basis that the request did not substantiate an E&M service. 2. The requestor submitted the billing again with code 99213 instead. Again, the documentation did not support an E&M service was billed. 3. The requestor is using an incorrect code to bill the service provided. Until the correct code is submitted Texas Mutual cannot issue any payment.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
4/6/2010	99213	N/A	\$100.84	\$0.00
			Total Due:	\$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

1. The first part of the document is a list of the names of the persons who were present at the meeting.

2. The second part of the document is a list of the names of the persons who were absent from the meeting.

3. The third part of the document is a list of the names of the persons who were present at the meeting.

4. The fourth part of the document is a list of the names of the persons who were present at the meeting.

5. The fifth part of the document is a list of the names of the persons who were present at the meeting.

Explanation of benefits dated 5/26/2010 for CPT code 99215

- CAC-B22 – This payment is adjusted based on the diagnosis.
- CAC-16 – Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 907 – Only treatment rendered for the compensable injury is reimbursable. Not all conditions indicated are related to the compensable injury.

Explanation of benefits dated 7/27/2010 for CPT code 99213

- CAC-16 – Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 732 – Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.

Explanation of benefits dated 9/1/2010 for CPT code 99213

- CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC-16 – Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 732 – Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
- No additional payment after reconsideration.

Issues

1. Did the requestor submit the dispute in accordance with 28 Tex. Admin. Code §133.307?
2. Does the submitted documentation support the services billed under CPT code 99213?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to rule §133.307(c)(2)(A)(B) Provider requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. The request shall include: a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter and a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. The provider submitted bills and EOB's with disputed CPT code 99213. The Carrier response included the original billing and original EOB with CPT code 99215. The requestor did not include the original billing or original EOB as originally submitted to the carrier with CPT 99215. Therefore, the requestor did not file this dispute in accordance with rule §133.307.
2. The Requestor listed the disputed CPT code as 99213 on the DWC-60 Table of Disputed Services. The description of this code is as follows: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family. This code does not require a modifier when billed alone and the carrier did not submit documentation to support that another procedure had previously been billed. Therefore, the Carrier's denial of "procedure code inconsistent with modifier used or modifier missing" is unsupported. The documentation the requestor submitted to support billing CPT code 99213 consists of 11 pages with Denise Weinberg, MSW, LMFT as the provider. Thorough review of the medical documentation shows that it does not meet the requirements for billing CPT code 99213. The medical documentation supports a psychiatric interview and even states at the top of the first page that it is a "clinical interview". The medical documentation also does not meet the signature requirements as outlined by Medicare. Pursuant to rule §134.203(a)(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers

for Medicare and Medicaid Services (CMS) payment policies specific to Medicare. The requestor's medical documentation was not submitted in accordance with rule §134.203.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.


Authorized Signature

 CPC
Medical Fee Dispute Resolution Officer

10/11/10
Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right. The names are: John Smith, James Brown, and William Jones. The dates are: 1810, 1811, and 1812. The list is followed by a signature, which is also in cursive script. The signature is: John Smith.